STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING _____ B. WING _____	12/18/2013

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LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	Life Care Center of Greeneville is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted December 16-18, 2013. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements. F272 1) Resident #218 Risk of Elopement/ Wandering Assessment completed immediately upon knowledge of incompleteness revealed by surveyor. 2) 100% audit completed on 12/18/13 revealed no other residents with incomplete Risk of Elopement/ Wandering Assessments. 3) a) Staff Development Coordinator completed 100% education on proper completion of Risk of Elopement/Wandering Assessments by 1/3/14. b) The Director of Nursing/Assistant Director of Nursing will review Risk of Elopement/Wandering Assessments to audit for compliance	2/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	1-3-14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to complete an assessment for one resident (#218) of forty-one residents reviewed. The findings included: Resident #218 was admitted to the facility on December 10, 2013, with diagnosis including Dementia, Altered Mental Status, and Hallucinations. Medical record review of a Risk of Elopement/Wandering Review, dated December 10, 2013, revealed "...Is the resident cognitively impaired with poor decision-making skills...Yes...If yes, comment on Side Two...Does the resident have a pertinent diagnosis of Dementia...Hallucinations...Yes...If yes, comment on Side Two...Does the resident ambulate independently...Yes...If yes, comment on Side Two...Does the resident wander aimlessly or non-goal directed...Yes...If Yes, comment on Side Two..." Continued review revealed no additional comments listed on Side Two. Review of facility policy, Elopement, revealed "...Procedure...3. A specific plan and interventions (including specific behavior patterns) are developed and implemented from the time of admission for those residents at risk for wandering or elopement..." Interview with Unit Manager #1 and Charge Nurse #2 on December 17, 2013, at 2:52 p.m., at the Aspen Hall nursing desk confirmed the	F 272	of proper completion weekly for 4 weeks and monthly for 2 months. 4) a) Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved. 1) a) Resident #218 wander guard placed on resident on 12/16/13. b) Resident #35 lap buddy immediately placed on resident on 12/18/13. Resident reassessed on 12/19/13 due to resident continually removing lap buddy, velcro seat belt placed due to unsafe transfers. 2) 100% audit of all safety devices ordered completed on 12/19/13 revealed no other residents without ordered safety devices in place.	F323	2/1/14

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F 272	Continued From page 2 assessment was not completed.		3) a) Nurse Unit Managers and/or Weekend Supervisors will check daily to ensure ordered safety devices are in place. b) The Director of Nursing/Assistant Director of Nursing will audit Nurse Unit Managers and/or Weekend Supervisors daily for completion of audits regarding safety devices and check safety device placement weekly for 4 weeks and monthly for 2 months. 4) a) Director of Nursing/Assistant Director of Nursing will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for two resident's (#218, #35) of six residents reviewed for accidents of forty-one residents reviewed. The findings included: Resident #218 was admitted to the facility on December 10, 2013, with diagnosis including Dementia, Altered Mental Status, and Hallucinations. Medical record review of a nurse's note dated December 10, 2013, at 6:45 p.m., revealed "...resident wanders through halls constantly..." Medical record review of the Interim Care Plan completed on admission revealed "...Elopement risk...Wandering and/or exit seeking behaviors...interventions...Wanderguard..." Observation on December 16, 2013, at 11:59 a.m., revealed the resident walking down the	F 323		

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F 323	Continued From page 3 South Cedar Hall to the exit door. Continued observation revealed the resident pushed on the exit door until the door opened and the alarm sounded. Observation revealed the resident started to exit the building when Charge Nurse #3 intervened. Continued observation revealed the resident was immediately escorted to the dining room by Speech Therapist #1. Interview with Unit Manager #1 on December 16, 2013, at 12:38 p.m., in the facility dining room revealed the resident did not have a wander guard in place. Interview with Charge Nurse #2 (the nurse who completed the interim care plan) on December 17, 2013, at 2:52 p.m., at the Aspen Hall nursing desk revealed the Charge Nurse was notified from the admitting hospital the resident may be an elopement risk. Continued interview confirmed the Charge Nurse listed a wanderguard as an intervention and had failed to place the safety device on the resident at the time of the admission. Resident #35 was admitted to the facility on July 27, 2009, with diagnoses including Aftercare for Healing Traumatic Fracture of Hip, Congestive Heart Failure, and Vascular Dementia. Medical record review of the quarterly Minimum Data Set (MDS) dated September 8, 2013, revealed the resident scored a 6 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognitive skills, required limited assistance for transfers and required extensive assistance with dressing.	F 323		

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F 323	Continued From page 4 Medical record review of the Progress Notes dated December 15, 2013, at 12:37 p.m., revealed the resident was found by housekeeping on the bathroom floor and complained of hip pain. Medical record review of a Physician Telephone Order dated December 16, 2013, revealed "Apply lap buddy as a restraint and check q (every) 30 min (minutes) release q 2 (hours)." Medical record review of the Care Plan dated July 27, 2009, and updated on December 11, 2013, revealed the resident was identified at risk for falls and an intervention dated December 16, 2013, to apply a lap buddy to the wheelchair. Observations on December 17, 2013, at 2:30 p.m., 4:00 p.m., and 4:49 p.m., revealed the resident in the main dining room seated in a wheelchair without a lap buddy in place. Observation on December 18, 2013, at 10:30 a.m., revealed resident self-propelled by wheelchair through the hallway and into the resident's room. Continued observation revealed the resident did not have a lap buddy in place. Interview with License Practical Nurse #1 on December 18, 2013, at 10:30 a.m., in the resident's room confirmed the lap buddy was not in place. Interview with Unit Manager #1 in the dining room on the Cedar Wing, on December 18, 2013 at 10:52 a.m., confirmed the facility had failed to ensure the safety device was in place for resident #35.	F 323		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 5 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturer's instructions, the facility failed to maintain a clean and sanitary kitchen and failed to ensure dietary supplements and milk were discarded when expired in one of three medication storage rooms reviewed and one of three nutritional refrigerators reviewed. The findings included: Observation on December 16, 2013, in the kitchen at 9:40 a.m., revealed: 1) Three of three bowls of cereal uncovered on a shelf in the dry storage area and available for use. 2) Twenty-four of twenty-four, 4 ounce cartons of milk shake dietary supplement with an expiration date of December 11, 2013, on the shelf of the walk in refrigerator available for resident use. 3) White chunky debris floating in the water of the third and fourth bin of the steam table.	F 371	1) a) 3 bowls of cereal uncovered on the shelf in the dry storage area were immediately discarded on 12/16/13. b) 24 of 4 ounce cartons of milkshake dietary supplement with expiration date of 12/11/13 were immediately discarded on 12/16/13. c) Steam table water changed immediately upon the finding of white chunky debris floating in the water of the 3rd and 4th bins. Pro Stat with expiration date of 12/11/13 was immediately discarded. The 7 thawed 4 ounce high calorie shakes 2 undated 1 dated 11/27/13 and 4 dated 12/02/13 were immediately discarded. One half pint carton of butter milk with expiration date of 11/23/13, one half pint carton of milk with expiration date of 11/10/13, one half pint carton of milk with expiration date of 12/9/13, and one half pint carton of milk with expiration date of 12/16/13 were immediately discarded. Four of 4 ounce cartons of thawed undated high calorie shakes were discarded. 2) a) 100% audit of proper storage of food in the dietary department was completed, revealed no items stored improperly on 12/16/13.	2/1/14

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F 371	Continued From page 6 Interview with the Certified Dietary Manager at the time of the observation confirmed the cereal was to be covered, the dietary supplements were to be discarded, and the water in the steam table needed to be changed. Observation of the Aspen Wing medication room on December 17, 2013, at 9:50 a.m., revealed one unopened thirty ounce bottle of Pro Stat sugar free liquid protein (nutritional supplement) with an expiration date of December 11, 2013. Continued observation in the nutritional supplement refrigerator revealed seven thawed 4 ounce high calorie shakes; two undated, one dated November 27, 2013, and four dated December 2, 2013. Observation of the refrigerator at the nurses' station on the Aspen Wing on December 17, 2013, at 10:05 a.m., revealed one half pint carton of buttermilk with an expiration date of November 23, 2013, one half pint carton of milk dated November 10, 2013, one half pint carton of milk dated December 9, 2013, and one half pint carton of milk dated December 16, 2013. Continued observation revealed 4 four-ounce cartons of thawed undated high calorie shakes. Review of the manufacturer's instructions for the use of the high protein shakes revealed "storage and handling: store frozen, thaw under refrigeration. After thawing, keep refrigerated. Use fourteen days after thawing." Interview with Unit Manager #1 at the Aspen Unit nurses station on December 17, 2013, at 10:05 a.m., confirmed the nutritional supplements and	F 371	b) 100% audit of expiration dates in walk in refrigerator revealed no additional out of date items on 12/16/13. c) Audit of steam table after water changed revealed no further debris present on 12/16/13. 100% audit of unit refrigerators completed and revealed no additional out of date or undated items on 12/17/13. 3) a) The Dietary Manager completed 100% education for dietary staff on proper storage of food in the dry storage area on 12/19/13. b) The Dietary Manager completed 100% education for dietary staff on proper dating of food items and to discard any items beyond expiration date on 12/19/13. c) The Dietary Manager completed 100% education for dietary staff to change steam table water after every meal on 12/19/13. The Staff Development Coordinator completed 100% education for night shift charge nurses to check for proper dating of food items and to discard any items beyond expiration date. Nightly audits of unit refrigerators will be completed by the charge nurse to ensure all items are in date 1/3/14.	

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F 371	Continued From page 7 milk were available for resident use and were beyond the expiration date.	F 371	d) The Nurse Unit Managers will check unit refrigerator audits daily for completion and The Director of Nursing/Assistant Director of Nursing will check to ensure items are dated properly weekly for 4 weeks and monthly for 2 months. The Dietary Manager will complete weekly audits in the dietary department to ensure food is stored properly in the dry storage area; items are dated properly in the walk in refrigerator, and the steam table water is changed after every meal and is free of debris for 3 months. 4) a) Director of Nursing/Assistant Director of Nursing and Dietary Manager will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	